STATE HEALTH BENEFIT PLAN

PARTNERS
V3 NEW ELIGIBILITY SYSTEM

October 2005

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Project Update

The Implementation Team continues to work with Vitech on the production of the Design Specifications. Work on the Design Specifications is expected to continue through the end of October.

The projected "go-live" date for V3 HPAS is March 1, 2006. That means Open Enrollment this fall and the first few months of the next Plan Year will be administered through MEMS. As has been discussed before, the member's tier (single or family) is driven by the dependents the member selects for coverage in V3 HPAS. This is not the case in the MEMS system. Therefore, members electing family coverage without identifying dependents will still be allowed to do so in MEMS; however, when V3 HPAS goes live it will retroactively adjust the tier back to January 1, 2006. There will be no adjustment to premiums for the coverage months of January through March. To avoid any discrepancies it is imperative for Benefit Coordinators to encourage their employees to only select family coverage when there are dependents to be covered under the contract.

Additionally, the following bears repeating: With "dependent driven tiers," members must insure that their dependents, particularly overage dependents on Student Status, are documented in a timely manner to avoid inadvertently changing coverage tiers in V3.

For example, if a 19-year-old child and the member are the only individuals on the contract, failure to document student status when required will end coverage for the child and adjust the tier and premium to reflect Single coverage from that point forward. Per SHBP business rules, late documentation on these dependents would not be accepted and they would not be eligible for re-enrollment until the following annual Open Enrollment period or other qualifying event. This, obviously, is potentially a very traumatic event for the member; however, SHBP must live up to its fiduciary responsibilities for the proper administration of the Plan.

Impact of Medicare on Benefits and Premiums

V3 HPAS will implement 2006 SHBP rules concerning premiums, subordination of benefits and claims payments in relation to retirees and their dependents over age 65. Georgia law requires that SHBP benefits be reduced by the amount of available Medicare benefits and authorizes SHBP to establish premiums to reflect Medicare coverage (O.C.G.A. 45-18-2). This means that SHBP calculates premiums and claims payments based upon the Medicare enrollment of members over age 65 and others eligible for Medicare due to disability. The SHBP will coordinate benefits for members who are enrolled in Medicare. The SHBP is a self-funded plan - that means benefits are paid from member premiums, employer contributions and legislative appropriations. Coordinating benefits prevents

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Impact of Medicare on Benefits and Premiums

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duplicate benefit payments which reduces SHBP financial liability and in turn helps control premiums.

The SHBP will continue to pay primary benefits for members and dependents not enrolled in Medicare but retiree premiums for those not enrolled will be increased to more closely reflect the growing unfunded liability for primary claims payments. New retiree premiums will take into consideration enrollment in Medicare Parts A and B and the new Part D, the Prescription Drug Plan (PDP).

Please tell your employees who are planning retirement to mail in a copy of their own or their dependents' Medicare cards to the SHBP. This includes their Part D prescription drug card ttrhat they will recieve from the PDP they select. Additional information on the Medicare Part D program is available by telephoning 1-800-633-4227 or visiting www.medicare.gov.

New! V3 HPAS Web Site Updates

- New link: www.dch.georgia.gov/shbp_hpas
- MPPI file layout (updated record types)
- Life Events Questions & Answers
  - What is a qualifying "Life Event" or "Change in Status Event?"
  - What should an employee do when they experience a life event change?
  - What type of documentation is needed for life event changes?
  - How long after the occurrence can I make the change?
  - I have no Health coverage. Am I eligible to elect Health coverage if I experience a life event change?
  - ….and more!!!

Why Collect Non-Eligible Employee Data?

Our goal is to provide the necessary data needed for State of Georgia "Cafeteria Plans" to conduct federally required non-discrimination testing. Although the SHBP is not considered a cafeteria-style benefit plan in itself, it is the health plan for other State of Georgia employers and, subsequently, part of several cafeteria plans. In order to facilitate testing, all employees, benefits eligible and non-benefits eligible, must be included.

Interfacing Update for Flex Agencies

For Rollout 1, the V3 HPAS team has previously communicated that SHBP would be interfacing with the Georgia Merit System Flexible Benefits Program (Flex), on a short term basis, as a "pass through" for employee benefits related data from PeopleSoft and the other Flex partners. The initial decision to use Flex was due to the restrictive timeframe under which we were implementing and leveraging an existing relationship through which the SHBP already receives data from Flex.

Since then, we have explored the option of implementing what was going to be the long term plan and initiated discussions with the State Accounting Office (SAO) to interface directly with them for the March 1, 2006, implementation (Rollout 1). In particular, we have discussed the files needed – a new employee/update file (including updates such as terminations, leave without pay, etc.) and a payroll deduction file. V3 would provide to SAO an update file showing premium changes made directly by members via V3 HPAS.

This decision will potentially affect the other Flex partners as well. V3 will also interface directly with those payroll locations or their representatives. We expect a decision very soon from the SAO on their ability to support direct interfacing with PeopleSoft.

Full Payment of the SHBP Monthly Bill

The SHBP is a self-funded plan which means benefits are not provided through an insurer. The SHBP is actually the insurer and is responsible for paying the medical bills of those covered through the not-for-profit plan. Even though the SHBP may contract with an HMO, insurer or other third-party administrator to process the claims, the SHBP still retains responsibility for funding the payment of those medical claims.

The monthly bill represents the cost of your employees' SHBP coverage. When your payroll records do not match the coverage records and your employee and employer contribution remittances do not match the amounts due, then the SHBP financial liability for your employees could exceed the SHBP revenue available to fund the payment of your employees' medical claims. Just as your homeowners or automobile insurers do not pay for losses when premiums have not been paid, SHBP should not be expected make benefit payments when premiums are not remitted.

V3 HPAS is being designed to help you keep payroll records synchronized with SHBP coverage records. Because SHBP understands its fiscal and fiduciary responsibilities to all members and Georgia tax payers, the system is also being designed to automatically and immediately suspend benefit payments for members whose payroll deduction records do not match SHBP coverage records. Additionally, V3 HPAS is being designed to provide SHBP the ability to suspend benefit payments for all members within an entire payroll location. **For example, a payroll location that does not remit the employee and/or employer contribution amounts in full each and every month, or fails to maintain payroll deduction records that match SHBP coverage records month after month, could have all benefit payments suspended until the problem is resolved.**

As we did in the June issue, we encourage you again to review your internal processes so you will be ready to take full advantage of the V3 HPAS features while insuring your employees' health benefits will always be available to them.

State Health Benefit Plan

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